421.417: Noncovered Services

The MassHealth agency does not pay for the treatment of male or female infertility, including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment~~.~~; however, MassHealth does pay for the diagnosis of male or female infertility.

(130 CMR 421.418 through 421.420 Reserved)

421.421: Coordination of Services

When a family planning agency is located in a community health center, a hospital, or another primary-care setting, the agency must demonstrate that family planning services are coordinated with and integrated into other services delivered on site. Such coordination includes at a minimum:

(A) either one central medical record for each member in which all medical and health-care services are recorded, or a mechanism for transferring relevant information to medical records to ensure continuity of care;

(B) avoidance of duplication of medical examinations and laboratory tests; and

(C) in-house referrals, as appropriate.

421.422: Emergency Backup

A family planning agency must have provisions for 24-hour emergency backup. Each member must be given the emergency telephone number in writing at the time of initiation of services. The telephone number must also be displayed prominently in the family planning agency.

421.423: Recordkeeping Requirements

(A) Payment for any service listed in 130 CMR 421.000 is conditioned upon its full and complete documentation in the member's medical record. A family planning agency must maintain a record of all medical and contraceptive services provided to a member for at least six years following the date of service. Every member visit or telephone call with the staff must be recorded. The documentation must include the reason for each visit or telephone call and any action taken.

(B) The medical record must contain, but is not limited to, the following information:
(1) the member's name, address, telephone number, date of birth, and MassHealth identification number;
(2) the date of service;
(3) the name, title, and signature of the person performing the service or making the contact;
(4) the type of visit (for example, annual or routine);
(5) medical history and history update;
(6) pertinent findings on examination;
(7) laboratory tests and results;
(8) abnormal findings and follow-up treatment;
(9) drugs administered or prescribed, including strength, dosage, route, regimen, and number of refills;
(10) drugs dispensed, including strength, dosage, route, regimen, and number of units;
(11) the contraceptive method used and any special instructions;
(12) a summary of counseling; and
(13) plans for follow-up.

(C) Basic information collected during previous visits with the member (for example, identifying data or medical history) does not need to be repeated in the medical record for subsequent visits as long as the entire medical record reflects continuity of care.